ZdravReform/ЗдравРеформ

Kyrgyzstan Health Reform Overview

October 1999

Submitted by the Zdrav*Reform* Program to:
USAID/CAR

Funded by:
AID Contract No. CCN-C-00-94-00023
Managed by Abt Associates Inc.
Almaty, Kazakhstan

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Introduction

Health reforms began in Kyrgyzstan in mid-1994 with the designation of Issyk-kul Oblast as the national health reform demonstration site and the WHO supported development of a national health reform plan termed the MANAS Program. From late 1994 to late 1996, the USAID-funded ZdravReform Program developed and implemented a comprehensive, integrated health reform model in Issyk-Kul Oblast. Positive results obtained in Issyk-Kul Oblast facilitated development of a productive collaboration between the World Bank and USAID. In 1997, the World Bank and the USAID-funded ZdravReform Program collaborated to roll-out the Issyk-kul health reform model to Bishkek City and Chui Oblast. Also in 1997, the ZdravReform Program was able to begin the process of institutionalizing health reform at the national level. In 1998, ZdravReform began the long process of rolling-out the health reform model to South Kyrgyzstan, to Osh and Jalal-Abad Oblasts.

One of the reasons for the success of health reform in Kyrgyzstan is the development and implementation of a comprehensive, integrated health reform model that addresses the problems of the health sector. While operational strategies and plans have varied with the rapidly changing environment, the basic health reform model has remained the same. It has provided stability in an uncertain environment and guided the path of reform. There are four main components of the health reform model: 1) Health delivery system restructuring and strengthening primary health care, 2) Population involvement, 3) New provider payment systems, and 4) New management information systems. Legal and policy framework, and public awareness are elements of each of these components.

Kyrgyzstan continues to move forward implementing all the components of the health reform model. Over 500 new Family Group Practices (FGP's) have been established nationwide to strengthen primary health care. Clinical training has been provided to FGP physicians and nurses in Issyk-Kul Oblast, Bishkek City, and Chui Oblast, and to FGP physicians in the four pilot areas of Osh and Jalal-Abad Oblasts through the national Family Medicine Training Center (FMTC) in Bishkek City and FMTC Affiliates in Issyk-Kul and Osh Oblasts. Training of course is an on-going process and needs to be continued.

A national Family Group Practice Association has been established in Bishkek City as an NGO with affiliates in Issyk-Kul, Osh, and Jalal-Abad Oblasts. A national Hospital Association has been established in Bishkek City as an NGO with affiliates in Osh and Jalal-Abad Oblasts. These NGO's have advocated and provided services to their respective members, FGP's and hospitals. In addition, they have contributed to the development of civil society and a democratic transition in Kyrgyzstan as increased power in decision making about health care can contribute to the desire for more democratic participation in other sectors of the economy.

The health reforms have involved the population in decisions about their health care by redefining both population rights and responsibilities. One new right of the population is the right to choose their primary health care provider. In Issyk-Kul Oblast, Bishkek City,

and Chui Oblast, approximately 80 percent of the population has exercised this right by voluntarily enrolling in the FGP of their choice. In addition to new rights, the population also has new responsibilities, particularly responsibility for their own health status. The ability of the population to manage and improve their own health status is being enhanced through extensive health promotion campaigns.

New provider payment systems contribute to economic restructuring by introducing competition, increasing health sector efficiency, and allowing health providers increased management autonomy to allocate resources more effectively. A new case-based hospital payment system was developed in Issyk-Kul Oblast and implemented nationally by the Health Insurance Fund (HIF). Over 60 hospitals or almost all the general hospitals in the country are now receiving part of their revenue under this new case-based hospital payment system. A new hospital information system was developed to support this hospital payment system and more than 400,000 hospital cases have been paid nationwide using this information system.

New capitated rate payment systems in which FGPs are paid a capitated rate per enrollee have been developed and implemented. The national HIF has contracts paying FGPs, under this new capitated rate system, with over 400 FGPs in Issyk-Kul Oblast, Bishkek City, Chui Oblast, and Osh and Jalal-Abad Oblasts. Issyk-Kul Oblast has also implemented this new FGP payment system using budget or general revenue funds as well as health insurance funds. A licensing and accreditation function has been established nationwide, requiring that hospitals and FGPs be licensed and accredited before being eligible to contract with the HIF.

New clinical and financial management systems for health providers have been developed and implemented. A December 1998 MOH prekazi cancelled old health statistics forms and replaced them with new clinical information forms, codes, and automated information systems which are being introduced in stages nationwide. New clinical protocols, health purchaser quality assurance systems, and health provider quality improvement techniques are being developed and implemented. Finally, a legal framework is being established to institutionalize the health reforms.

Implementation of all the components of the health reform model continues throughout Kyrgyzstan. It is important to note that Kyrgyzstan has adopted a very process oriented, step-by-step approach to health reform. A national MOH and HIF Joint Working Group develops health reform strategy that outlines both a broad vision and operational plans containing a series of steps required to realize this vision. Incremental steps are introduced which strengthen the foundation and produce small victories which lead to larger victories.

The MOH in Kyrgyzstan has been successful in coordinating and integrating contributions from a multitude of donors including USAID, the World Bank, WHO, the British Know How Fund, GTZ, the Swiss Development Agency, and the Asian Development Bank. The collaboration between USAID and the World Bank has been particularly fruitful. The World Bank was impressed by the Issyk-Kul Oblast health reform demonstration and began

the process of widening the demonstration by including a roll-out of the health reform model to Bishkek City and Chui Oblast in the first World Bank Project. USAID provided technical assistance to support this roll-out to Bishkek City and Chui Oblast. A second World Bank Project is currently being developed to extend the health reforms nationally and continued technical assistance from USAID will increase the probability of national roll-out of the Issyk-Kul health reform model and sustainability of the health reforms.

Many of ZdravReform's Central Asia program strategies have been developed and tested in Kyrgyzstan, including criteria for a successful demonstration project and the demonstration widening or roll-out process; collaboration with the World Bank; the contribution of health reform to economic restructuring and democratic transition; development of a successful regional program; and integration of infectious diseases and reproductive health into primary health care to increase sustainability and health sector efficiency. In addition, Kyrgyzstan has contributed many "lessons learned" which inform and improve the health reform process throughout the Former Soviet Union.

The remainder of this paper is organized by defining events in the development of health reform in Kyrgyzstan. The following discussion of these defining events, occurrences, which have had a significant impact on the course of health reform, is organized chronologically to illustrate the progression of the reforms in Kyrgyzstan.

Issyk-Kul Oblast Demonstration Site

Issyk-Kul Oblast was chosen as the national health reform demonstration site in mid-1994 by the Ministry of Health (MOH) of Kyrgyzstan. In late 1994, health reforms were initiated with a series of training seminars introducing various concepts, including health delivery system restructuring, health management, health insurance, accreditation, and cost accounting. By summer of 1995, a ZdravReform Office had been established, staffed by an expatriate resident advisor and local staff. The site office worked intensively on building a foundation and implementing the health reform model in Issyk-kul Oblast over the next two years, supported by technical staff from the Almaty Regional Office. In mid-1997, the health reforms, though still fragile and unsustainable, had taken root and the process of widening or roll-out through collaboration with the World Bank had begun.

While the Issyk-kul Oblast demonstration has been a success, experience has shown that continued support is necessary for a number of reasons. First, although the basic ZdravReform Program Central Asia health reform model was fairly well established by 1995, lessons learned from implementation have ensured that operational strategies continued to evolve. Many of the early adjustments to the model were developed in the Issyk-kul Oblast demonstration. For example, it became crystal clear that health delivery system restructuring and changes in health financing were not sufficient to drive health reform. The basic nature of clinical practice must be changed. This resulted in a shift in focus of the ZdravReform Program which has continued to this day which emphasized family medicine clinical training.

Second, in the early stages, the health reforms were very fragile and unsustainable. For

example, while Issyk-kul Oblast had successfully formed 81 new primary care entities called Family Group Practices (FGP's), their role in a health sector dominated by hospitals was still uncertain. Until the FGPs were strengthened and their scope of service expanded, resources and service provision could not be transferred from hospital care to more cost-effective primary health care. In addition, infectious diseases and reproductive health which had been treated through a specialized system now had to be incorporated into primary health care in order for the system to become more cost-effective. In other words, though restructuring the health delivery system and building a new, more efficient primary health care sector is vital to the success of health reform, the roles and relationships between primary health care, outpatient specialty care and inpatient care must also be redefined.

Third, the process of rolling-out the Issyk-kul health reform model to the entire country of Kyrgyzstan required continued visible success and lessons learned from the Issyk-Kul Oblast demonstration. Health reformers in other parts of Kyrgyzstan needed Issyk-Kul Oblast to convince an entrenched and unprogressive health sector that health reform was necessary and a positive change. This situation continues to the present day.

A final reason why continued support for the Issyk-Kul demonstration site is necessary is that health reform is a step-by-step process where many subsequent steps are built on the foundation established in prior steps. For example, until FGPs are strengthened through clinical training, the scope of services they provide to the population cannot be expanded and solidified by the financial incentives of new provider payment systems. Also, health authorities are understandably reluctant to grant FGPs more management autonomy until their capabilities have improved. Many of these subsequent steps are now being realized in Issyk-Kul.

The major accomplishments of the Issyk-Kul Oblast demonstration are summarized as follows:

- 81 new Family Group Practices were formed in stages from early 1995 through mid-1996
- FGPs were strengthened through the provision of family medicine training for FGP physicians and nurses in Issyk-kul Oblast from 1996 through the present
- FGPs began to incorporate infectious diseases and reproductive health into primary health care
- A new health sector NGO, the Family Group Practice Association, was established and developed
- Over 85% of the population were enrolled in FGPs as a result of intensive marketing campaigns held in stages over the last half of 1996
- Extensive health promotion campaigns were held using mass media (television, radio, and newspapers) and other channels such as information brochures and community meetings
- Institutional capacity-building and development of the Oblast Health Department and the Health Insurance Fund, in health care reforms
- A new case-based hospital payment system was developed
- New provider payment systems were implemented under the Health Insurance Fund

using payroll tax funds – case-based system for hospitals and capitated rate system for FGP's

- New provider payment systems were developed and implemented using budget funds -- a capitated rate system for FGPs
- New health information systems were developed, tested, implemented, and refined in Issyk-Kul Oblast and later implemented at the national level
- A new health sector career was established and developed – practice managers for FGPs.
- A policy and legal framework for health reform was developed

In summary, the Issyk-Kul Oblast demonstration site both triggered the health reform process in Kyrgyzstan and serves as an on-going impetus for health reform by continuing to identify and overcome barriers to reform.

Design of the First World Bank Health Sector Reform Project

Kyrgyzstan designed and implemented the first World Bank Health Sector Reform Project in Central Asia. Many of the design assumptions and parameters from this project have carried over into the World Bank Projects currently being implemented (Kazakhstan and Uzbekistan), and designed (Tajikistan) in Central Asia.

As the Kyrgyzstan Health Sector Reform Project was the first in Central Asia, the World Bank strived to establish a balance between addressing the MOH's critical short-term health and humanitarian needs, and developing a more efficient, sustainable health delivery system for the long-term. The initial stages of design in early 1995 brought only limited success in finding this balance. For example, the Ministry of Health (MOH) wanted the project to provide drugs. While the World Bank recognized and wanted to address this need, they also wanted to invest in improving the efficiency of the health delivery system to increase long-term sustainability.

In mid-1995, discussions between the USAID-funded ZdravReform Program and the World Bank design team contributed positively to establishing this balance. World Bank senior health advisors were impressed with the design of the Issyk-Kul Oblast demonstration and wanted to extend the health reforms to Bishkek City and Chui Oblast as a component of the World Bank Health Sector Reform Project. Including roll-out of the Issyk-Kul Oblast health reform model into the project provided the balance that allowed project design to move forward.

Over the next year, the ZdravReform Program contributed substantial technical assistance to the design of the first World Bank Health Reform Project in Kyrgyzstan. When the project became effective in late 1996, ZdravReform began to collaborate with the World Bank Health Reform Project in the roll-out of the Issyk-Kul health reform model to Bishkek City and Chui Oblast.

Crisis Surrounding the Role of Health Insurance

Initial implementation of the World Bank Health Sector Reform Project was hampered by a crisis concerning the role of health insurance and the new Health Insurance Fund (HIF) in the health sector of Kyrgyzstan. On the positive side, resolution of this issue triggered the process of institutionalizing the health reforms at the national level.

The initial World Bank position was that health insurance was irrelevant to the World Bank Health Reform Project. However, it was ZdravReform's contention that introducing a new health purchaser into the health sector would have an enormous impact on the implementation of new provider payment systems, one of the core elements of the project. In the winter of 1997, the issue of the institutional roles and relationships between the two public health purchasers, the HIF and the MOH, "blew-up". The result was the World Bank Project was stopped until this issue could be resolved. This is an important issue, as is its' resolution.

The introduction of health insurance and the establishment of a new Health Insurance Fund as second health purchaser in addition to the MOH created many problems in Russia and Kazakhstan. For example, health policy was not coordinated between the MOH and HIF and health sector functions were duplicated increasing administrative costs. Restructuring the health sector was difficult because two provider payment systems created contradictory financial incentives, and two benefit packages created inequity and confusion among the population. Providers were incapable of managing payment from two sources, and fraud and abuse increased.

When health insurance was introduced and the Health Insurance Fund established in late 1996, the World Bank Project was stopped in order to resolve this issue and avoid the problems experienced by Russia and Kazakhstan. The ZdravReform Program, together with the World Bank and Kyrgyz counterparts developed a new concept, approved by the Government in mid-1997, called the Coordinated Policy for the Implementation of Health Reform and Health Insurance. This policy introduced MOH and HIF Jointly Used Systems to enable the MOH and HIF to function as a single-payer in the health sector while remaining as separate institutions with separate sources of financing. The MOH and HIF Jointly Used Systems consisted of five systems -- information, provider payment, accounting, quality assurance, and benefits coordination.

The MOH and HIF Jointly Used Systems functioned very well in the initial stages of health reform and over the next year the reforms in Kyrgyzstan progressed rapidly because the MOH and HIF coordinated health policy in an effective manner.

Roll-Out of the Issyk-kul Health Reform Model to Bishkek City and Chui Oblast through USAID and World Bank Collaboration

In early 1997, experienced local staff were relocated from Issyk-Kul to Bishkek in order to establish an office and begin implementation of health reform in Bishkek City and Chui Oblast in collaboration with the World Bank. The World Bank Project procured technical assistance from Abt Associates. However, the amount of technical assistance the Kyrgyz Government was willing to borrow for was minimal and substantial ZdravReform inputs

were required to implement the project. This situation is illustrative of the foundation of the World Bank and USAID collaboration – USAID brings technical assistance the government does not want to borrow for and the World Bank brings substantial investment in commodities and political leverage.

The roll-out of health reforms to Bishkek City and Chui Oblast moved rapidly. By mid-1998, 118 FGPs had been formed in Bishkek City and 172 FGPs had been formed in Chui Oblast. The task of strengthening the FGPs was proceeding well through provision of equipment, renovations, and clinical training. In late 1998, over 80% of the population of Bishkek City and Chui Oblast, more than one million people, exercised their right of free choice of primary care provider and enrolled in the FGP of their choice. Health promotion campaigns began to increase the responsibility of the population for their health status. National health sector NGOs, the Family Group Practice Association and Hospital Association, were established, and their capability to advocate and provide services to their members increased. New provider payment systems and health information systems were developed, tested, and implemented under the Health Insurance Fund.

As in Issyk-kul, health reform in Bishkek City and Chui Oblast has taken root, but is not yet sustainable. Progress continues under the USAID and World Bank collaboration to strengthen the health reform.

Institutionalization of Health Reform at the National Level

A process-oriented approach was established at the national level to develop the policy and legal framework for health reform and a step-by-step approach to implementation. A MOH and HIF Joint Working Group was established to develop health policy, strategies, and operational plans. Technical Joint Working Groups were also established to address issues such as clinical information, provider payment, pharmaceuticals, and quality assurance. The Joint Working Group process was very successful in developing a health policy framework.

Work began to establish a legal framework based on the health policies developed by the MOH and HIF Joint Working Group. Many pieces of the legal framework have been put in place over the last few years. For example, national FGP regulations, Health Insurance Fund organization and provider payment regulations, regulations for health information systems, and important government decrees such as reinvestment of savings in the health sector have been approved. However, much more work is needed, particularly in the areas of allocation of budget funds, continued restructuring of the health sector, and clinical practice.

In addition to establishing a policy and legal framework for implementation of health reform at the oblast level, many elements of health reform were also implemented at the national level. As Kyrgyzstan is a small country, it was decided that many of the provider payment systems and health information systems could be implemented nationally.

In 1997, the Health Insurance Fund began implementation of a new national case-based

hospital payment system. Over 60 hospitals, or almost all the general hospitals in Kyrgyzstan, are currently being paid under this system. In 1998, the Health Insurance Fund began contracting with FGPs as they were formed, paying them through a capitated rate payment system.

Extensive health information systems have been developed and are being implemented at the national level. In December 1998, a MOH prekazi cancelled many of the old health statistics forms, replacing them with forms and systems developed by the ZdravReform Program. This was a major step on the road to sustainability. While the new health information systems developed by ZdravReform operated the new provider payment systems, contributed to quality assurance and research, and provided better data for decision-making for both health purchasers and health providers, the new information systems were running parallel to the old systems. Relinquishing the old system allows the new health information system to develop more rapidly and cost-effectively.

As discussed above, Kyrgyzstan made extremely rapid progress in the implementation of health reform from early 1997 through mid-1998. However, in mid-1998, progress slowed as political events resulted in a break-down of the coordinated MOH and HIF health policy. This lack of coordination of health policy between the MOH and HIF led the MOH to recognize that it was time to establish a health sector institutional structure viable in the long-term.

In December 1998, Kyrgyzstan took another major step forward by merging the HIF under the MOH to create a single-payer in the health sector. The MOH and HIF Jointly Used Systems had bought time and allowed the health reforms to progress rapidly by avoiding the problems faced by Russia and Kazakhstan. However, the pace of reform had slowed significantly because of the inability of the MOH and HIF to coordinate policy.

There are several reasons why a single-payer is the most appropriate health purchaser institutional structure in Kyrgyzstan. First, it allows the major advantage of the Soviet system to be retained – universal coverage with relatively equal access and equity for the population. A multi-payer system on the other hand segments the population and inevitably results in unequal access, usually for vulnerable populations.

In addition, a single-payer allows a single institution to have control over all the parameters or elements of health reform. In implementing health reform in the Former Soviet Union (FSU), changes in health financing and provider payment systems are necessary, but not sufficient. The structure of the health delivery system also has to change. A single-payer can restructure the health sector as well as introduce new provider payment systems. In addition, the single-payer can address issues ranging from setting broad health policy, to improving clinical practices and quality, to establishing and improving health information systems.

In summary, Kyrgyzstan has taken major steps toward institutionalizing health reform at the national level and enhancing sustainability in the long-term. Kyrgyzstan along with all Former Soviet Union countries faces enormous hurdles in restructuring the health sector to

provide lower cost, higher quality health services to the population. Kyrgyzstan's step-by-step approach has allowed the country to keep moving forward in health reform, identifying and removing each hurdle along the way. The job is not finished and there are many important obstacles which still need to be addressed, some of which are discussed in the section on "Next Steps".

Beginning the process of institutionalizing the health reforms at the national level facilitated the on-going process of rolling-out the health reform model across oblasts. The next section discusses roll-out to South Kyrgyzstan.

Roll-Out of the Health Reform Model to Osh and Jalal-Abad Oblasts in South Kyrgyzstan

In early 1998, the MOH requested assistance from USAID to begin the process of rolling-out or extending the health reforms to South Kyrgyzstan – Osh and Jalal-Abad Oblasts. As South Kyrgyzstan is large, containing approximately 50% of the population, it was decided to roll-out in stages using pilot sites. There are currently four pilot sites in South Kyrgyzstan. Osh Oblast pilot sites are Aravan and Now-Kat Rayons. Jalal-Abad pilot sites are Jalal-Abad City and Bazaar-Korgon Rayon.

Similar to the World Bank collaboration, the USAID-funded ZdravReform Program has developed a collaboration with the Asian Development Bank (ADB). The ADB has designed a Social Sector Project in South Kyrgyzstan, focusing on health and education. While the project was supposed to become effective last spring, it has been delayed and is expected to become effective in the fall of 1999.

In health, the ADB Project will focus on rural infrastructure. It will provide equipment and renovations for newly formed FGPs in rural areas. The Osh and Jalal-Abad Family Group Practice Associations will be involved in decisions concerning equipping and renovating rural FGP's. The ZdravReform Program plans to provide some equipment and renovation for urban FGPs as they are not covered under the ADB Project. As ZdravReform has limited funding, the second World Bank Project planned to start in 2001 will finish equipping and renovating urban FGP's.

Over the last year, ZdravReform has worked with counterparts in Osh and Jalal-Abad to establish the Family Group Practice Association and Hospital Association as health sector NGOs serving as vehicles for health reform, formed 54 FGP's, and provided clinical training for more than 300 FGP physicians. ZdravReform also has initiated health promotion campaigns targeting the population, collected and analyzed health sector data, facilitated the implementation of national provider payment systems, and developed and implemented new health information systems.

Although the health reforms in Osh and Jalal-Abad Oblasts have been initiated very rapidly, much work remains. The health reforms in the pilot sites need to be deepened and then widened or rolled-out throughout South Kyrgyzstan. In addition, the health reforms need to be integrated into the ADB Project when it finally becomes effective.

Initial Stages of Roll-Out to Naryn and Talas Oblasts

Institutionalization of health reform in a national policy and legal framework has resulted in the initialization of the first stages of health reform in the two remaining Kyrgyzstan oblasts of Naryn and Talas. The ZdravReform Program is contributing to developing the pre-conditions for health reform in Naryn and Talas by starting to establish Family Group Practice Associations, beginning to collect data for analysis, beginning to include participants in training seminars.

Clearly, a presence and considerable intensive technical assistance is required to roll-out health reforms to Naryn and Talas Oblasts. ZdravReform will continue to support activities to develop the pre-conditions for health reform until the end of the current contract in June, 2000. At that point a decision should be made on whether to more intensively roll-out the reforms to Naryn and Talas Oblasts.

Role of Kyrgyzstan as a Regional Health Reform Leader

The role of Kyrgyzstan in triggering health reform in other Central Asian countries should not be underestimated. The countries of Central Asia still face the same problems in their health sectors. They look to each other for new interventions and also to learn from experiences and avoid mistakes.

Countries including Russia, Ukraine, Mongolia, Tajikistan, Kazakhstan, Uzbekistan, and Turkmenistan have sent representatives for site visits of the Kyrgyz reforms. Tajikistan in particular has been influenced by the health reforms in Kyrgyzstan. The Central Asian countries are requesting more regional seminars such as the health reform conference held in Issyk-kul Oblast in the summer of 1999. Kyrgyzstan is a leader in health reform in Central Asia -- it keeps raising the bar and setting a standard that influences the health reform process in other countries.

Results

Appendix A presents three impacts of the health reforms on the efficiency and effectiveness of the health sector.

Next Steps

Next steps can be defined through three parameters which can be used to frame the health reforms in Kyrgyzstan – the demonstration strategy, the health reform model, and the collaboration with the World Bank.

The parameter of the demonstration strategy can usually be described by geography. In Kyrgyzstan, the geographic next steps are fairly clear. The Issyk-Kul Oblast demonstration site should be **maintained** to improve sustainability and present a visible example of health reform. The reforms in Bishkek City and Chui Oblast need to be **strengthened and**

deepened. The reforms in Osh and Jalal-Abad Oblasts need to be deepened in the pilot areas and **expanded** throughout the remainder of the oblasts. Finally, the reforms in Naryn and Talas need to be **initiated.** If this demonstration or geographic strategy is followed, the health reforms will encompass all oblasts and the entire population of Kyrgyzstan.

Next steps programmatically consist of continuing to develop and implement elements of the four components of the health reform model -- health delivery system restructuring and strengthening primary health care, population involvement, new provider payment systems, and new management information systems. A major programmatic focus must be to continue to integrate and ensure consistency among the components of the health reform model. For example, clinical practice must be consistent with the restructured health delivery system, and the financial incentives of the new provider payment systems must be consistent with the expanded scope of service of FGP's.

Specific programmatic next steps are outlined below:

1. Solve the major remaining issue hampering the health reforms, pooling budget funds at not less than the oblast level. Until this issue is resolved and new provider payment systems implemented without budget chapters, the health reforms are not sustainable.
2. Strengthen the national policy and legal framework to continue institutionalizing health reform.
3. Continue to strengthen established FGPs through clinical training, incorporation of infectious diseases and reproductive health into primary health care, and strengthening of laboratory services. Form FGPs wherever they are not established so restructuring primary care has occurred nationwide.
4. Reorganize and integrate the public health system into the restructured health delivery system.
5. Continue to support the development of health sector NGOs including the Family Group Practice Association and the Hospital Association.
6. Enroll the population wherever this has not occurred so that the entire population of Kyrgyzstan is enrolled in an FGP.
7. Continue to involve the population in decisions about their health care by redefining population rights and responsibilities and implementing health promotion campaigns.
8. Restructure and realign the outpatient specialty and inpatient sectors to adapt to a stronger primary health care sector, resulting in a more efficient health delivery system providing lower cost, higher quality health services to the population.
9. Continue implementation and refinement of new provider payment systems and management information systems nationwide.

Finally, next steps for the third parameter, collaboration with the World Bank, consist of continuing to collaborate on implementation of the first World Bank Health Reform Project, and the provision of technical assistance to design and implement a successful second World Bank Health Reform Project. After the second World Bank Project it is reasonable to expect that the health reforms in Kyrgyzstan would be sustainable.

The first World Bank Project ends December, 2000. The Government of Kyrgyzstan and

the World Bank have agreed there will be a second World Bank Project from 2001-2005. The main objective of the second World Bank Project will be to expand the health reforms nationwide. The health reform model initially demonstrated in Issyk-Kul Oblast will be rolled-out throughout the entire country. Issues including the structure of hospitals and polyclinics in relationship to FGP's, broad health financing strategy, quality improvement, strengthening public health, MOH policy development and evaluation functions, and medical and health management education will also be addressed in order to help ensure long-term sustainability of the health reforms.

Appendix A

Impact of Health Reforms on Health Sector Efficiency in Kyrgyzstan

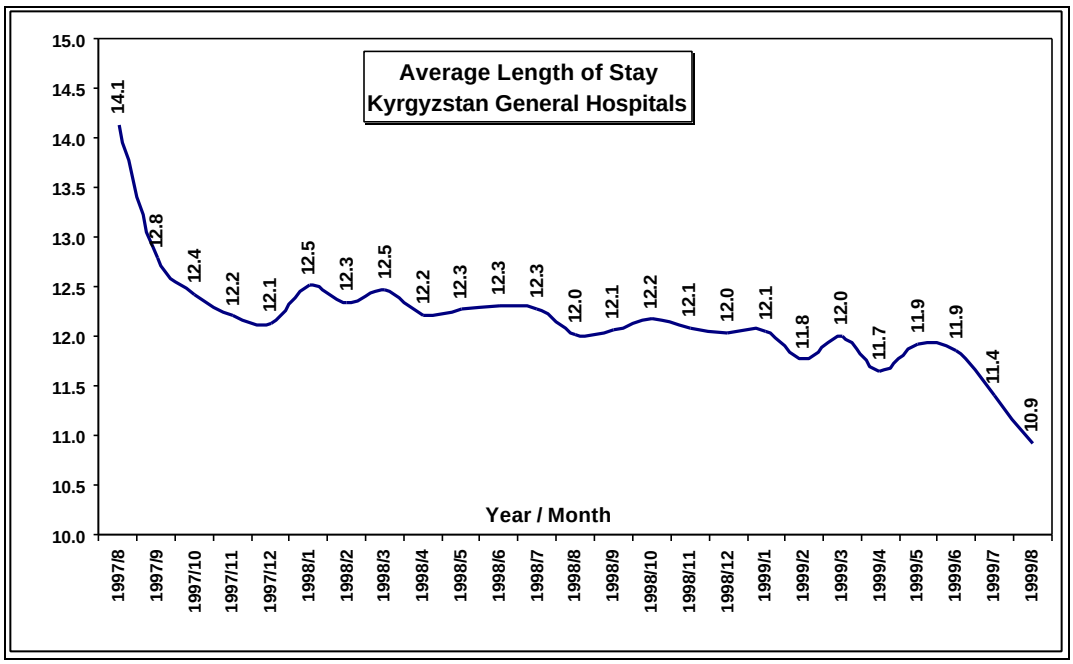
III Hospital Length of Stay

The health delivery system in Kyrgyzstan resembles an inverted pyramid. The hospital sector is overdeveloped, containing massive amounts of excess capacity. Therefore, it is very inefficient, consuming more than 70% of health sector resources. Primary health care is the most cost-effective health service, but it is underdeveloped and needs to be strengthened. One objective of health reform is to strengthen primary health care (through the formation of new primary care entities called Family Group Practices) and shift resources from inpatient or hospital care to primary health care.

The old hospital payment system was a budget system that allocated funds based on production input measures such as number of beds. It contained a direct financial incentive to increase and maintain capacity. The result is a health service delivery system with too many hospitals and too many beds. A new case-based hospital payment system was introduced in Kyrgyzstan to contribute to the rationalization of the hospital sector and a shift of resources to the more cost-effective primary health care sector. The hospital payment system creates competition among hospitals and allows them more management autonomy to allocate resources more effectively.

One indicator of hospital efficiency is length of stay (LOS), the average number of days each patient remains in the hospital. The LOS in Kyrgyzstan is approximately three times higher than the United States. The old hospital payment system contained financial incentives to increase LOS, while the new case-based hospital payment system contains financial incentives to decrease LOS.

A national case-based hospital payment system was implemented in Kyrgyzstan in August 1997 by the Health Insurance Fund. Over 60 general hospitals throughout Kyrgyzstan are now being paid under this new hospital payment system. The chart below shows the change in LOS across these 60 general hospitals over the last two years – from implementation of the hospital payment system in August 1997 through August 1999. The source of information is the hospital payment information system developed and implemented by the ZdravReform Program. It contains 486,000 hospital cases which represent bills submitted for each hospital case in order to receive payment.



The average LOS in the 60 general hospitals included in the new case-based hospital payment system has decreased from 14.1 days in August 1997 to 10.9 days in August 1999, a decrease of 23 percent. This decrease in LOS means that hospitals are functioning more efficiently, creating savings which can be reinvested in improved health services for the population. While the decrease in LOS does not result in realization of savings until hospitals rationalize or downsize their capacity, the competition and management autonomy created by the new hospital payment system encourages hospitals to undertake this rationalization.

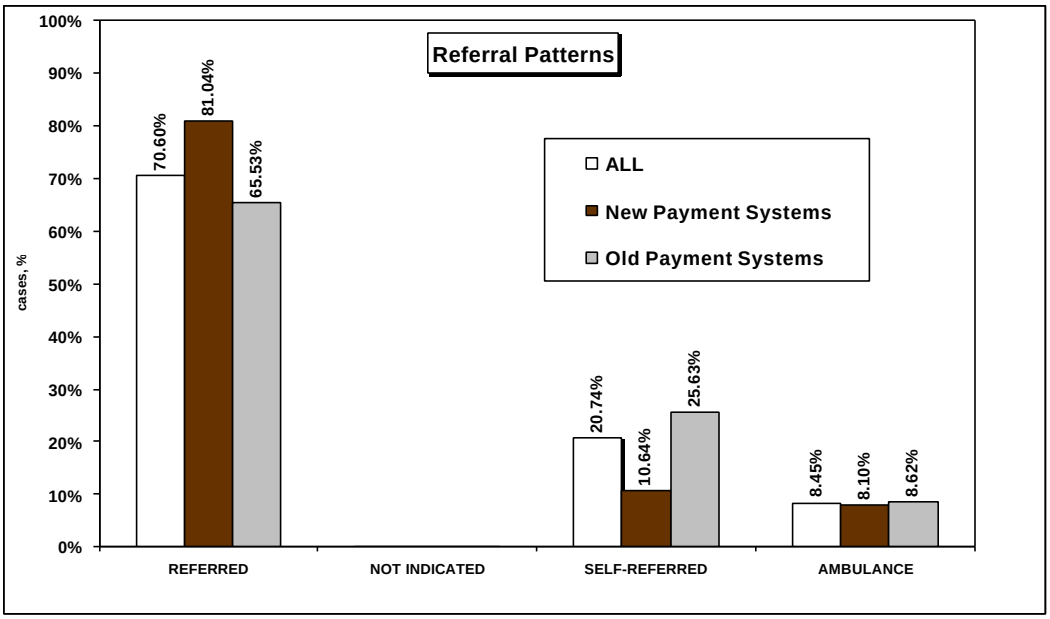
Primary Care Referrals

One way to evaluate the impact of health reform on health delivery system effectiveness is the level of referrals from primary health care to other levels of the health delivery system. While primary health care is the most cost-effective level of service, the primary health care sector in Kyrgyzstan is underdeveloped and needs to be strengthened. Family Group Practices are being formed to strengthen primary health care and expand its scope of service, meaning that medical conditions formerly treated in hospitals can be treated in Family Group Practices. The level of referrals indicates whether primary health care is expanding its scope of service.

To effectively strengthen primary health care, the health delivery system must be strengthened and financial incentives introduced through new provider payment systems to encourage health providers and the population to utilize primary care services. These financial incentives to guide utilization of health services are being introduced in Kyrgyzstan through the new case-based payment system for hospitals and the new capitated rate payment system for FGP's.

The Health Insurance Fund introduced a policy into its new case-based hospital payment system effecting how the health delivery system is utilized. Hospital cases will not be paid unless the patient is referred to the hospital by a FGP or other outpatient provider. This policy and the attached financial incentive strongly encourages the population to use primary health care services rather than self-refer to hospitals. The combination of strengthening primary health care and introducing financial incentives to utilize primary health care results in a more efficient health sector providing lower cost, higher quality health services to the population.

The impact of the Health Insurance Fund policy concerning self-referral is shown by the referral chart below. The hospital payment database containing 486,000 cases is the source of referral data. The clinical information form or bill contains mandatory information on the source of referrals to the hospital.



The sources of referral in this chart are referral from a FGP or other outpatient provider, self-referral meaning that the patients refer themselves to the hospital, and ambulances. Under the new hospital payment system, the level of self-referrals dropped from 25.63% to 10.64% over the time period from August 1997 to August 1999. This is a 58% drop in the rate of self-referrals meaning that patients are utilizing primary health care more often and the health delivery system is functioning more effectively.

Infant Mortality

World-wide, the major health outcome measure remains infant mortality. The chart below compares national infant mortality with Issyk-Kul Oblast infant mortality.

Location	1996	1997	1998
All Kyrgyzstan	25.9	28.3	26.0
Issyk-Kul Oblast	25.0	23.7	23.8

It is not possible to directly correlate changes in infant mortality to health reform due to the number of variables involved, for example, economic and social environment. However, it is worth noting that while the national infant mortality rate increased over the last three years, the infant mortality rate in Issyk-kul showed a decrease from 1996, sustained over the last two years.

The general feeling is that reductions in infant mortality in the current economic environment are unrealistic, with a realistic goal being to avoid increases in infant mortality. Issyk-Kul Oblast is actually decreasing infant mortality and while this should not be completely attributed to health reform, most likely health reforms in Issyk-kul Oblast contributed to this result.